# NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
# INSTRUCTIONS FOR COMPLETING
# APPLICATION FOR PROVIDER ENROLLMENT

## RESIDENTIAL SERVICES

Residential Services providers must file an application for enrollment as a Medicaid provider and sign a provider agreement to qualify for reimbursement for Level II, III, IV HRI-Residential Services, and Psychiatric Residential Treatment Facility services. A separate application and provider agreement must be completed for **each business site**. The enrollment process includes the following steps:

1. Provider requests enrollment with the Division of Medical Assistance (DMA). Provider Services can be reached at 919-857-4017.
2. DMA sends the provider a Residential Services provider application and a provider agreement.
3. Provider completes the application, signs the provider agreement, and forwards both documents, along with the required credentials to:

   Provider Services
   Division of Medical Assistance
   2506 Mail Service Center
   Raleigh, NC 27699-2506

4. If the application or agreement are not completed properly, DMA returns the document(s) for correction or for additional information.
5. If the provider meets all qualifications, DMA assigns a provider number, which must be entered on all claims for reimbursement of services rendered.
6. DMA sends the provider a letter with the provider number and a copy of the signed provider agreement.
7. The provider begins billing upon receipt of the provider number and provider agreement.
8. The provider is responsible for applying for re-enrollment before the enrollment end date to ensure continued enrollment. The enrollment end date will be the earlier of 1) the end date of the accreditation credential or 2) the end date of the license.

**Important points to remember**

- **Each** residential service **site** must have a separate application and provider agreement.
- Facilities must have four beds or more.
- All parts of the Residential Services provider application must be completed. Signature must be original.
- All pages of the provider agreement must be returned to DMA. The provider receives a signed copy in the mail.
- Copies of accreditation and licensure must accompany the application. If these documents are missing, the application is returned to the provider. Permissible license types are:

  Level II, III, and IV Residential: 14V.1300, 14V.1500, 14V.5200
  PRTF: Hospital license or 14V.1500

- The accreditation document must have an end date.
- Services cannot be billed until the provider receives notification of the provider number. The notification letter will include the effective date.

# NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
# APPLICATION FOR PROVIDER ENROLLMENT

## RESIDENTIAL SERVICES

_____
Name of Business/Agency

_____ (___)_____
Site Address Phone

_____
City State Zip

_____
Mailing Address (if different from above)

1) Please check the services for which you are applying to provide. Each **site** must have a separate provider number and provider agreement. More than one type of service may be provided at a site if all service definition requirements are met.

| Check Desired Service | Required Accreditation Credential | Required License |
|---|---|---|
| ___ Level II HRI - Residential<br>___ Level III HRI - Residential<br>___ Level IV HRI - Residential | Copy of JCAHO, COA, CARF*, Area Mental Health Program or NC Division of MH/DD/SAS accreditation showing end date of accreditation period **or** a copy of a current Area Mental Health Program contract showing contract period | Copy of license as required by G.S.122C from the N.C. Division of Facility Services (14V.1300, 14V.1500, or 14V.5200) |
| ___ Psychiatric Residential Treatment Facility | Copy of JCAHO, COA, or CARF accreditation showing end date of accreditation period | Copy of license as required by G.S. 122C or G.S. 131E, Article 5 from the N.C. Division of Facility Services (Hospital license or 14V.1500) |

* JCAHO – Joint Commission on the Accreditation of Healthcare Organizations
COA – Council on Accreditation of Services for Families and Children
CARF – Rehabilitation Accreditation Commission

2) Number of beds in the residential placement: _____

3) Is the placement state-owned: ( ) Yes ( ) No

4) Is the residential placement hospital-based? ( ) Yes ( ) No

Name of associated hospital: _____

5) Have individuals or organizations having a direct or indirect ownership or control interest of 5% or more in this business been convicted of a criminal offense related to the involvement of such persons or organizations in the programs of Medicaid (Title XIX), Medicare (Title XVIII or Social Services Block Grant (Title XX)?

____ Yes (Provide names in this space or attach documentation.)

____ No

6) Have any directors, officers, agents, or managing employees of the agency or organization been convicted of a criminal offense related to their involvement in the programs of Medicaid, Medicare, or Social Services Block Grant?

____ Yes (Provide names in this space or attach documentation.)

____ No

**SIGNATURE OF PROVIDER:**

_____

Printed Name of Owner or Corporate Officer Title

_____

Signature of Owner or Corporate Officer

Please enclose a copy of the applicable accreditation credential and license with a completed provider participation agreement and mail to:

Provider Services
Division of Medical Assistance
2506 Mail Service Center
Raleigh, NC 27699-2506